UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

NON-SEDATING ANTIHISTAMINES

(Xyzal, Allegra, Clarinex)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Extensions and options_____Fax#_____

Pharmacy_____Pharmacy Phone#_____

Medication being
requested_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES TO (801) 536-0477

CRITERIA:

- **DOCUMENTATION** stating when and how OTC loratadine and cetirizine preparations have failed.

INFORMATION: non-sedating antihistamines limited to 30 doses/30 days.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.

7/19/6